ATTACHMENT XI (b)

STATE OF CALIFORNIA
EMERGENCY MEDICAL SERVICES AUTHORITY
1999 STATEWIDE Y2K HOSPITAL READINESS EXERCISE

EXERCISE BED AVAILABILITY FORM

***** This form should reflect bed status as of 1400 hrs. on September 16, 1999 *****

Please complete the information below for your facility and fax it to the normal designated county representative/agency at 1430 hrs.

1

Name of Facility:_____

2

Address:_____ City:_____ Zip:_____

4

3 Disaster Coordinator:_____ Telephone #:_____

5

FAX:_____ email:_____ County:_____

6 Facility State License #: _____

As of: 1400 hrs. On: Sept. 16, 1999	**Census** (# of currently admitted patients) A	**Estimated # of patients that you can admit at time of census with current staffing levels** B	**Estimated # of additional patients you can admit within two hours.** C
7 **Medical/Surgical Beds** (Please combine categories)			
8 **Critical Care/ICU Beds** (Please combine categories)			
9 **Pediatric Beds**			
10 **OB Beds**			
11 **All Other Beds** (eg. Psych, Rehab., SNF, etc.)			
12 **Total**			

FACILITY STATUS (Please circle one):

13 **Green** **Yellow** **Red** **Black**

"Green": Facility is able to carry out normal operational functions.

"Yellow": Some reductions in patient services, but overall, facility is able to carry out normal operational functions.

"Red": Significant reductions in patient services. Emergency services only being provided.

"Black": Facility has been severely affected. Unable to continue any services.